Marcia S. Gibson PsyD
& Associates, P.C.

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL HEALTH INFORMATION

I, _____, hereby authorize to release to/or secure from
Patient/Client (PRINT)

_____
(Name of Health Care Facility, Physician, Agency, etc.)

_____
Office Phone Number Office Fax Number

_____
(Street Address, City, State and Zip Code)

The following information contained in the client record of

_____ _____
(Client's Name) (Date of Birth)

To be disclosed, the following items must specifically be checked:

☐ Account Information ☐ Treatment Summary

☐ Office Psychotherapy Notes ☐ Verbal Discussion of Case

☐ Psychological Testing Report ☐ Other (Specify): _____

The purpose(s) of the authorization is (are):

☐ At the request of the individual ☐ Coordination of Mental Health Treatment

☐ Payment of Account ☐ Other (specify): _____

I understand that the practice may not condition treatment on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law.
I understand that I may be responsible for the cost of medical record copying service.
I understand that this authorization is valid until it expires, unless revoked before that. I understand that I may revoke this authorization at any time by giving written notice to the practice of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the therapist has already relied on it to use or disclose my health information. Written revocation must be sent to the practice. Absent such written revocation, this Authorization for Release of Confidential Information will terminate on _____
(Date)

_____ _____
Signature of Patient/Client Date

_____ _____
Signature of Witness Signature of Parent or Guardian

** Client signature is required in addition to the parent of guardian signature for children ages 12-17 **